

Linda K. Whitney
Executive Director

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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 12-2009-202222

12 **ANDREW M. GIOVANNINI, M.D.**

13 3490 20th Street, Suite 201
14 San Francisco, CA 94110-2582

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

15 **Physician's and Surgeon's Certificate No. G 10958**

16 Respondent.

17 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
18 entitled proceedings that the following matters are true:

19 **PARTIES**

20 1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of
21 California. She brought this action solely in her official capacity and is represented in this matter
22 by Kamala D. Harris, Attorney General of the State of California, by Kerry Weisel, Deputy
23 Attorney General.

24 2. Respondent Andrew M. Giovannini, M.D. (Respondent) is represented in this
25 proceeding by attorney Kenneth H. Wine of the law firm of Hallinan & Wine, 345 Franklin
26 Street, San Francisco, California 94102.

27 3. On July 26, 1965, the Medical Board of California issued Physician's and Surgeon's
28 certificate Number G 10958 to Andrew M. Giovannini. The Physician's and Surgeon's certificate

1 was in full force and effect at all times relevant to the charges brought herein. The certificate
2 expired on November 30, 2011.

3 JURISDICTION

4 4. An Accusation in Case No. 12-2009-202222 was filed before the Medical Board of
5 California (Board), Department of Consumer Affairs, and is currently pending against
6 Respondent. The Accusation and all other statutorily required documents were properly served
7 on Respondent on December 1, 2011. A copy of the Accusation in Case No. 12-2009-202222 is
8 attached as exhibit A and incorporated in this stipulation by reference.

9 ADVISEMENT AND WAIVERS

10 5. Respondent has carefully read and understands the charges and allegations in the
11 Accusation in Case No. 12-2009-202222. Respondent has also carefully read and understands the
12 effects of this Stipulated Surrender of License and Order.

13 6. Respondent is fully aware of his legal rights in this matter, including the right to a
14 hearing on the charges and allegations in the Accusation; the right to be represented by counsel at
15 his own expense; the right to confront and cross-examine the witnesses against him; the right to
16 present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel
17 the attendance of witnesses and the production of documents; the right to reconsideration and
18 court review of an adverse decision; and all other rights accorded by the California
19 Administrative Procedure Act and other applicable laws.

20 7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
21 every right set forth above.

22 CULPABILITY

23 8. For the purpose of resolving the charges and allegations in the Accusation in Case
24 No. 12-2009-202222, as well as any potential or future charges and allegations in relation to the
25 matters currently under investigation in Case No. 12-2010-211706, Respondent agrees that the
26 charges and allegations in the Accusation in Case No. 12-2009-202222, if proven at a hearing,
27 constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. To avoid
28

1 the expense and uncertainty of further proceedings, Respondent hereby gives up his right to
2 contest those charges.

3 9. Respondent understands that by signing this stipulation he is enabling the Board to
4 issue an order accepting the surrender of his physician's and surgeon's certificate without further
5 process.

6 CONTINGENCY

7 10. Pursuant to section 2224(b) of the Business and Professions Code, this stipulation
8 shall be subject to approval by the Medical Board of California. Respondent understands and
9 agrees that counsel for Complainant and the staff of the Medical Board of California may
10 communicate directly with the Board regarding this stipulation and settlement, without notice to
11 or participation by Respondent. By signing the stipulation, Respondent understands and agrees
12 that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the
13 Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and
14 Order, the Stipulated Surrender of License and Order shall be of no force or effect, except for this
15 paragraph; it shall be inadmissible in any legal action between the parties; and the Board shall not
16 be disqualified from further action by having considered this matter.

17 11. The parties understand and agree that facsimile copies of this Stipulated Surrender of
18 License and Order, including facsimile signatures, shall have the same force and effect as the
19 originals.

20 12. In consideration of the foregoing admissions and stipulations, the parties agree that
21 the Board may, without further notice or formal proceeding, issue and enter the following Order:

22 ORDER

23 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 10958 issued
24 to Respondent Andrew M. Giovannini, M.D. is surrendered and accepted by the Medical Board
25 of California.

26 13. Respondent shall lose all rights and privileges as a physician and surgeon in
27 California as of the effective date of the Board's Decision and Order.
28

14. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

15. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement and Respondent shall comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed and all of the charges and allegations contained in the Accusation in Case No. 12-2009-202222 shall be deemed to be true, correct, and admitted by Respondent when the Board determines whether to grant or deny the petition. Information gathered in connection with this Accusation and in connection with currently pending investigation number 12-2010-211706 may be considered by the Board in determining whether, and on what terms, to grant a petition for reinstatement. Respondent hereby waives any time-based defense he might otherwise have to the Board's considering the charges contained in the Accusation in Case No. 12-2009-202222 and investigation number 12-2010-211706 including, but not limited to, the equitable defense of laches.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Kenneth H. Wine. I understand the stipulation and the effect it will have on my physician's and surgeon's certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/9/2012

Andrew M. Giovannini M.D.
ANDREW M. GIOVANNINI, M.D.
Respondent

I have read and fully discussed with Respondent Andrew M. Giovannini, M.D. the terms and conditions and other matters contained in the above Stipulated Surrender of License and Order. I approve its form and content.

DATED: 5/9/2012

Kenneth H. Wine
KENNETH H. WINE
Attorney for Respondent

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Dated: May 9, 2012

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General

Key Thief

KERRY WEISEL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation, Case No. 12-2009-202222

1 KAMALA D. HARRIS
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10 **MEDICAL BOARD OF CALIFORNIA**
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13 In the Matter of the Accusation Against:

14 **ANDREW M. GIOVANNINI, M.D.**
3490 20th Street, Suite 201
San Francisco, CA 94110-2582

15 **Physician's and Surgeon's Certificate No. G 10958**

16 Respondent.

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 1, 2011
BY [Signature] ANALYST

Case No. 12-2009-202222

17 **ACCUSATION**

18 Complainant alleges:

19 **PARTIES**

- 20 1. Linda K. Whitney ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California.
- 21 2. On or about July 26, 1965, the Medical Board of California issued Physician's and Surgeon's certificate Number G 10958 to Andrew M. Giovannini ("Respondent"). The Physician's and Surgeon's certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2011, unless renewed.

22 **JURISDICTION**

- 23 3. This Accusation is brought before the Medical Board of California, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code provides in pertinent part that the Board “shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

6. “(a) Violating . . . any provision of this chapter.

“(b) Gross negligence.

“ . . . ”

7. Section 725 of the Code provides, in part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

8. Section 2242(a) provides that prescribing, dispensing, or furnishing dangerous drugs as defined in section 4022 without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

9. Section 2266 of the Code provides that “[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.”

DRUGS

10. Hydrocodone bitartrate w/APAP (hydrocodone with acetaminophen) tablets are produced by several drug manufacturers under trade names such as Vicodin, Norco or Lortab. Hydrocodone bitartrate is semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022 and a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code. Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence. The usual adult dosage is one tablet every four to six hours as needed for pain. The total 24 hour dose should not exceed 6 tablets. The maximum 24 hour dosage of acetaminophen should not exceed 4000 mg. At high

1 levels, acetaminophen can cause liver toxicity and even death.

2 11. Methadone hydrochloride is a synthetic narcotic analgesic with multiple actions
3 quantitatively similar to those of morphine. It also goes by the trade names Methadose and
4 Dolophine. It is a dangerous drug as defined in section 4022 and a schedule II controlled
5 substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety
6 Code. Methadone can produce drug dependence of the morphine type and, therefore, has the
7 potential for being abused. Psychic dependence, physical dependence, and tolerance may develop
8 upon repeated administration of methadone, and it should be prescribed and administered with the
9 same degree of caution appropriate to the use of morphine. Methadone should be used with
10 caution and in reduced dosage in patients who are concurrently receiving other narcotic
11 analgesics. The usual adult dosage is 2.5 mg. to 10 mg. every three to four hours as necessary for
12 severe acute pain.

13 12. MS Contin is a trade name for morphine sulfate controlled release tablets. MS
14 Contin 100 tablets contain 100 mg of morphine sulfate. Morphine sulfate is for use in patients
15 who require a potent opioid analgesic for relief of moderate to severe pain. Morphine is a
16 dangerous drug as defined in section 4022, a schedule II controlled substance and narcotic as
17 defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Morphine can
18 produce drug dependence and has a potential for being abused. Tolerance and psychological and
19 physical dependence may develop upon repeated administration.

20 13. Norco. See description of Norco under hydrocodone with APAP, above. Norco
21 10/325 reflects that each pill contains 10 mg of hydrocodone bitartrate and 325 mg of
22 acetaminophen.

23 14. OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets.
24 Oxycodone is a white odorless crystalline powder derived from the opium alkaloid, thebaine. It is
25 a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of
26 oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a dangerous
27 drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by
28 section 11055, subdivision (b)(1) of the Health and Safety Code. OxyContin is a mu-antagonist

1 opioid with an abuse liability similar to morphine. If a broken oxycodone extended-release tablet
2 is ingested, the entire dose of oxycodone is delivered at once, instead of slowly over 12 hours and
3 may cause serious problems, including overdose and death.

4 15. Oxycodone hydrochloride. See description of oxycodone hydrochloride under
5 Oxycontin, above.

6 16. Vicodin. See description of hydrocodone bitartrate w/APAP, above. Vicodin
7 contains 5 mg of hydrocodone and 500 mg of acetaminophen. Vicodin ES contains 7.5 mg of
8 hydrocodone and 750 mg of acetaminophen. Vicodin HP contains 10 mg of hydrocodone and
9 660 mg of acetaminophen.

10 FACTS

11 17. At all times relevant to this matter, Dr. Giovannini was licensed and practicing
12 medicine in San Francisco, California.

13 PATIENT P-1¹

14 18. Dr. Giovannini first saw Patient P-1, a 49 year old woman, on February 26, 2009.
15 P-1 complained of chronic low back, neck, and shoulder pain among other things. Dr. Giovannini
16 obtained medical records from P-1's prior health care providers and had her sign a narcotic
17 medication agreement.

18 19. P-1's prior medical records included a report of an MRI of her left shoulder done
19 on February 11, 2003 showing tendinitis and mild to moderate impingement. Dr. Giovannini did
20 not order any additional diagnostic testing. He diagnosed P-1 with lumbar radiculopathy, cervical
21 traumatic arthritis, and shoulder tendinitis and prescribed OxyContin and Norco for her pain.

22 20. P-1 saw Dr. Giovannini monthly at least through November 11, 2010. He
23 prescribed high doses of OxyContin and Norco 10/325 throughout the time he treated her. For
24 the 12 month period ending in 2010, he prescribed an average of approximately 530 mg of
25 OxyContin a day.

26
27 ¹ The patients are designated in this document as Patients P-1 through P-5 to protect their
28 privacy. Respondent knows the names of the patients and can confirm their identity through
discovery.

1 21. Dr. Giovannini did not order any diagnostic testing during the time he was treating
2 P-1. In July 2009, Dr. Giovannini revised his diagnoses to cervical degenerative disc disease,
3 lumbar degenerative disc disease, lumbar radiculitis, and shoulder osteoarthritis with synovitis.

4 22. Dr. Giovannini did not order urine screens for P-1; did not order CURES reports;
5 and did not refer P-1 for orthopedic, neurological, or psychiatric consultation.

6 23. Dr. Giovannini's medical history and documented physical examinations were
7 limited and inadequate. Many of his office notes are virtual duplicates.

8 24. Dr. Giovannini documented very limited reappraisals of P-1's condition during the
9 time he was treating her with exceptionally large amounts of narcotic medications.

10 **FIRST CAUSE FOR DISCIPLINE**
11 (b) (Gross Negligence, Excessive Prescribing)

12 25. Respondent's license is subject to disciplinary action for unprofessional conduct in
13 violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross
14 negligence), and section 725 (excessive prescribing) in that he failed to document a sustained
15 effort to reduce the very large doses of habit-forming medication he was prescribing for P-1,
16 failed to conduct an adequate examination and to order imaging studies to justify his continued
17 prescribing of large doses of narcotic medication, failed to reappraise P-1's condition over the
18 time he was treating her, and/or failed to refer P-1 for consultation with specialists concerning her
19 condition and medications.

20 **PATIENT P-2**

21 26. Dr. Giovannini first saw Patient P-2, a 49 year old man, on March 2, 2009. On his
22 registration form, P-2 reported two bulging and 1 degenerative discs in his lower back, hip
23 "pointers" in his left hip, and a "bum" left knee. The records include an unsigned narcotic
24 medication agreement. Dr. Giovannini did not obtain P-2's prior treatment records.

25 27. Dr. Giovannini did not order any diagnostic testing of P-2. He diagnosed P-2 with
26 left lumbar disc herniation/radiculopathy L5/S1 and prescribed 180 oxycodone 30 mg tablets and
27 120 MS Contin 100 mg tablets for him.

28 28. Dr. Giovannini saw P-2 again March 10, 2009 and prescribed 120 OxyContin 80

1 mg tablets and 120 OxyContin 40 mg tablets for him. Dr. Giovannini saw P-2 again April 13,
2 2009 and continued the OxyContin prescriptions and increased the amount of oxycodone
3 prescribed.

4 29. Dr. Giovannini next saw P-2 on September 30, 2009. Again, he did no diagnostic
5 testing. He revised P-2's diagnosis to lumbar spine degenerative joint/disc disease and left
6 lumbar spine radiculopathy, L5 and S1. He renewed the OxyContin prescription and once again
7 increased the amount of oxycodone, now prescribing 250 tablets.

8 30. Dr. Giovannini saw P-2 monthly through at least May 3, 2010. He increased the
9 dose of OxyContin on December 30, 2009 and continued prescribing high doses of OxyContin
10 and oxycodone throughout the time he treated P-2. For the five month period following
11 December 30, 2010, Dr. Giovannini prescribed an average of over 800 mg of oxycodone
12 (OxyContin and oxycontin hydrochloride) a day.

13 31. Dr. Giovannini had an individual patient profile listing controlled substance
14 prescriptions filled by P-2 from January 1, 2009 through March 31, 2009 reflecting that P-2 had
15 filled prescriptions from other physicians for methadone, oxycodone, oxycodone with
16 acetaminophen, and hydrocodone with acetaminophen after Dr. Giovannini had begun treating
17 and prescribing for him. There is no evidence in the medical records that Dr. Giovannini
18 discussed this with P-2.

19 32. On April 29, 2010, the Berkeley Health Center contacted Dr. Giovannini's office
20 to advise him that P-2 was seeing multiple physicians and getting narcotic medication from at
21 least two physicians other than Dr. Giovannini. There is no evidence in the medical records that
22 Dr. Giovannini discussed this with P-2. On May 3, 2010, Dr. Giovannini prescribed 250
23 oxycodone 30 mg tablets, 120 OxyContin 80 mg tablets, and 180 oxycodone 40 mg tablets for P-
24 2.

25 33. Dr. Giovannini did not order urine screens for P-2, did not order CURES reports,
26 and did not refer P-2 for orthopedic, neurological, or psychiatric consultation.

27 34. Dr. Giovannini's medical history, documented physical examinations, and
28 progress notes were limited.

1 **SECOND CAUSE FOR DISCIPLINE**

2 (Gross Negligence, Excessive Prescribing, Inadequate Documentation)

3 35. Respondent's license is subject to disciplinary action for unprofessional conduct in
4 violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross
5 negligence), section 2266 (inadequate documentation), and section 725 (excessive prescribing) in
6 that he failed to document a sustained effort to reduce the very large doses of habit-forming
7 medication he was prescribing for P-2, failed to conduct an adequate examination and to order
8 imaging or electrodiagnostic studies to justify his continued prescribing of large doses of narcotic
9 medication, continued prescribing large doses of narcotic medication with knowledge that P-2
10 was obtaining prescriptions for narcotic medications from other physicians, and/or failed to refer
11 P-2 for consultation with specialists concerning his condition and medications.

12 **PATIENT P-3**

13 36. Dr. Giovannini first saw Patient P-3, a 35 year old man, on April 9, 2007. P-3
14 complained of knee pain. Dr. Giovannini had P-3 sign a narcotic medication agreement and had
15 x-rays taken which showed loss of lateral joint space and traumatic arthritis. Dr. Giovannini did
16 not obtain P-3's prior treatment records. He diagnosed P-3 with chondromalacia patella, anterior
17 cruciate ligament insufficiency, knee effusion, and abnormal gait.

18 37. Except for a short gap in early 2008, Dr. Giovannini saw P-3 monthly through at
19 least November 22, 2010. He prescribed high doses of OxyContin and oxycodone throughout the
20 time he treated him. He began by prescribing approximately 400 mg of oxycodone (OxyContin
21 and oxycodone) daily and quickly escalated the amount. By November 22, 2010, he was
22 prescribing over 1100 mg of oxycodone (OxyContin and oxycodone) a day for P-3.

23 38. Except for the x-rays on his first visit, Dr. Giovannini did not order any diagnostic
24 testing during the time he was treating P-3. He did not document discussion of other treatment
25 options such as local heat, cortisone injections, hyaluronic acid injections, surgery, or knee
26 replacement. The records mention physical therapy every visit from July 13, 2009 to November
27 22, 2010—a seventeen month period—but the records do not reflect any referrals to or
28 consultations with a physical therapist.

1 39. Dr. Giovannini did not order urine screens for P-3, did not order CURES reports,
2 and did not refer P-3 for orthopedic or other consultation.

3 40. Dr. Giovannini's medical history and documented physical examinations were
4 limited and the records contain no family or social history focusing on the history of addiction,
5 alcoholism, or suicide.

6 **THIRD CAUSE FOR DISCIPLINE**
7 (b) (Gross Negligence, Excessive Prescribing)

8 41. Respondent's license is subject to disciplinary action for unprofessional conduct in
9 violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross
10 negligence), and section 725 (excessive prescribing) in that he failed to document a sustained
11 effort to reduce the very large doses of habit-forming medication he was prescribing to P-3; he
12 failed to try or discuss other treatment options such as local heat, plain Tylenol, cortisone
13 injections, hyaluronic acid injections, surgery, or knee replacement; and/or failed to seek a second
14 opinion concerning P-3's condition and medication use.

15 **PATIENT P-4**

16 42. Dr. Giovannini first saw Patient P-4, a 45 year old man, on January 23, 2003. P-4
17 complained of severe chronic right wrist pain from lifting a heavy weight on March 19, 2002
18 while incarcerated. Dr. Giovannini diagnosed P-4 with ulnar nerve entrapment after fracture of
19 ulnar styloid and right wrist tendinitis.

20 43. P-4 developed neck pain, low back pain, left shoulder pain, and left knee pain and
21 underwent wrist, knee, and shoulder surgery during the nearly eight years that Dr. Giovannini
22 treated him. Over that time, Dr. Giovannini prescribed increasing amounts of opioid medication
23 for P-4.

24 44. P-4 was known to Dr. Giovannini to have a history of alcohol and crack cocaine
25 abuse and to have used crack cocaine during the time Dr. Giovannini was treating him. There is
26 no evidence that Dr. Giovannini obtained social and family histories for drug addiction, illicit
27 drug use, depression, and suicide from P-4; he did not use opioid risk questionnaires or scales
28 with P-4; he did not do urine screens of P-4; he did not obtain CURES reports for P-4; and he did

1 not seek a second opinion concerning P-4's medication use.

2 45. In 2010, P-4 developed hypogonadism secondary to narcotic use. For the last six
3 months in 2010, Dr. Giovannini was prescribing well over a thousand mg a day of oxycodone
4 (OxyContin and oxycodone) for P-4.

5 **FOURTH CAUSE FOR DISCIPLINE**
6 (Gross Negligence, Excessive Prescribing)

7 46. Respondent's license is subject to disciplinary action for unprofessional conduct in
8 violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross
9 negligence), and section 725 (excessive prescribing) in that he failed to document a sustained
10 effort to reduce the very large doses of habit-forming medication he was prescribing to P-4,
11 prescribed very large doses of narcotic medication over seven years to a patient with a history of
12 substance abuse, failed to adequately monitor P-4's use of narcotic medication, and/or failed to
13 seek a second opinion concerning the narcotic medication he was prescribing for P-4.

14 **PATIENT P-5**

15 47. Dr. Giovannini first saw Patient P-5, a 48 year old woman, on May 31, 2000. P-5
16 complained of low back pain radiating into both legs after moving furniture. Dr. Giovannini
17 diagnosed acute severe lumbar sprain. He prescribed Vicodin for P-5. The records include an
18 unsigned narcotic medication agreement.

19 48. On P-5's February 13, 2001 visit, Dr. Giovannini added lumbar disc herniation to
20 his diagnosis. Dr. Giovannini saw P-5 once a month through most of 2001. He did not see her in
21 2002 and resumed treatment in October 2003. He saw her periodically until mid to late 2006
22 after which he saw her monthly—or more frequently than monthly—through at least October
23 2010.

24 49. Beginning in 2003, Dr. Giovannini began prescribing Vicodin HP, a stronger
25 version of Vicodin containing higher levels of both hydrocodone and acetaminophen, for P-5.
26 Over time, he prescribed increasing amounts of Vicodin HP. Near the end of 2007, Dr.
27 Giovannini added 15 mg tablets of oxycodone to the Vicodin HP. By late 2008, he had increased
28 the strength of the oxycodone tablets from 15 mg to 30 mg.

1 50. From December 24, 2008 through January 28, 2010, the average daily number of
2 Vicodin HP tablets Dr. Giovannini prescribed for P-5 ranged from a low of 6.4 to a high of 13.8.
3 All but two of the prescriptions for Vicodin HP during that timeframe were for 8.6 or more tablets
4 a day. The amount of acetaminophen in the tablets prescribed for P-5 ranged from 4224 mg to
5 9108 mg per day and the amount of hydrocodone from 64 mg to 138 mg. During this same
6 period, the average daily number of oxycodone 30 mg tablets ranged from 7.1 to 15.4; that is 213
7 mg to 462 mg. All but two of the oxycodone prescriptions during that timeframe were for 9.5 or
8 more tablets a day.

9 51. Dr. Giovannini's history, physical, and progress notes for P-5 are limited with no
10 evidence of social and family histories for drug addiction, illicit drug use, depression, and suicide.
11 Dr. Giovannini did not use opioid risk questionnaires or scales with P-5, he did not do urine
12 screens of P-5, he did not obtain CURES reports for P-5, and he did not seek a second opinion
13 concerning P-5's condition or medication use.

14 **FIFTH CAUSE FOR DISCIPLINE**
15 (b) (Gross Negligence, Excessive Prescribing)

16 52. Respondent's license is subject to disciplinary action for unprofessional conduct in
17 violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross
18 negligence), and section 725 (excessive prescribing) in that he failed to document a sustained
19 effort to reduce the very large doses of habit-forming medication he was prescribing to P-5, failed
20 to adequately monitor P-5's use of narcotic medication, prescribed dangerously high levels of
21 acetaminophen for P-5, and/or failed to seek a second opinion regarding P-5's condition and the
22 narcotic medication he was prescribing for P-5.

23 **PRAYER**

24 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
25 and that following the hearing, the Medical Board issue a decision:

26 1. Revoking or suspending Physician's and Surgeon's certificate Number G 10958
27 issued to Andrew M. Giovannini, M.D.;

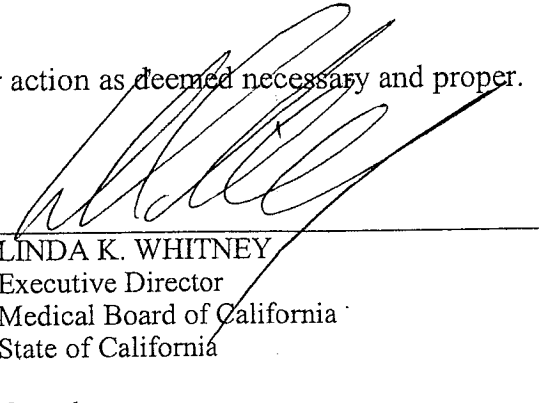
28 2. Revoking, suspending, or denying approval of Andrew M. Giovannini's authority

1 to supervise physician assistants, pursuant to section 3527 of the Code;

2 3. Ordering Andrew M. Giovannini, if placed on probation, to pay the costs of
3 probation monitoring; and

4 4. Taking such other and further action as deemed necessary and proper.

5
6 DATED: December 1, 2011



LINDA K. WHITNEY
Executive Director
Medical Board of California
State of California

Complainant